Please print clearly so we can process your information quickly and efficiently. Thank you!

FIRST NAME: _____ MI: _____ LAST NAME: _____

NICKNAME: _____ DOB: ____/_____/_____ AGE: _____

SOCIAL SECURITY #:_____-_____-_____ GENDER: M F

MAILING ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ POSTAL CODE: _____

EMPLOYER:_____ADDRESS:_____

CELL: (____)_____-_____ HOME: (_____)_____-_____WORK: (_____)_____-_____EXT: _____

EMAIL ADDRESS: _____

REFERRED BY: _____ PATIENT _____INTERNET _____MAGAZINE _____INSURANCE

_____ FLYER _____ OTHER

RESPONSIBLE PARTY NAME:_____RELATIONSHIP:_____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE #: (____)_____-_____ SOCIAL SECURITY #: _____-_____-_____ D.O.B:___/___/_____

INSURANCE COMPANY:_____

MEMBER #/SUBSCRIBER ID: _____ GROUP: _____

PHARMACY: _____ CITY: _____ PHONE: (___) _____–_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE: _____

I hereby assign, transfer, and set over to Vivify Wellness Center, PLLC all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

PATIENT SIGNATURE: _____ DATE: _____/_____/_____